Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Alta Vista Healthcare 5445 La Sierra Dr. #204 Dallas, TX 75231	MFDR Tracking #: M4-07-4693-01 D Injure D
Respondent Name and Box #: Zurich American Insurance Co Rep Box #: 19	Emp Insurar

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUM

Requestor's Position Summary: "The services (PPE) were paid below MAR."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $213.05
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principal Documentation:

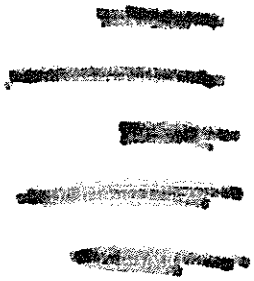
1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/20/06	97750	151, 213	1, 2, 3, 4	$213.05
Total Due:				$213.05

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.



1. These services were denied by the Respondent with reason code "151-Payment adjusted because the payer deems the information submitted does not support this many services." and "213-The charge exceeds the scheduled value and/or parameters that would appear reasonable."
2. Communication with the Respondent's representative verified that medical necessity is not a part of the "213" denial.
3. CPT Code 97750 has a MAR of $35.51 based on $28.41 x 125% per time unit. Documentation provided to Respondent supports 2 hours or (8 units of 15 minute increments) of services performed during time frame 1:00 PM to 3:00 PM. This would entitle Requestor to a total of $284.08. Respondent has already paid an amount of $71.03 for 2 units. The difference of previously paid reimbursement due of $213.05 to Requestor per Rule 134.202(c)(1).
4. Per review of Box 32 on CMS-1500, zip code 78212 is located in Bexar County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

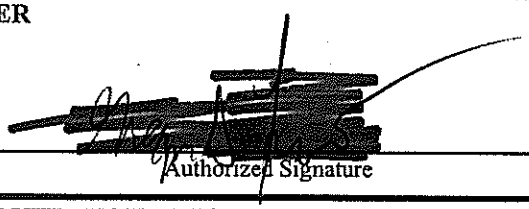
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $213.05 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER



Authorized Signature	[redacted] Medical Fee Dispute Resolution Officer	10/01/07 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.